NEW PATIENT INFORMATION

Name:_____
Last First M.I.

Adress:_____
Street Apt# City State Zip

Phone:_____ **Socaial Security #:**_____ DL#:_____

***E-Mail*:**_____ **Date of Birth:**_____ **Sex:**_____

Occupation:_____ **Employer:**_____

Employer Address:_____ **Phone:**_____
Street

_____
City State Zip

Name of Spouse/Parent:_____ **Employer:**_____

Employer Address:_____ **Phone:**_____
Street

_____
City State Zip

NAME OF PRIMARY INSURANCE CO:
_____ **Subscriber:**_____ **DOB:**_____

ID#:_____ **Policy/Group:**_____

(Secondary):_____ **Subscriber:**_____ **DOB:**_____

ID#:_____ **Policy/Group:**_____

CHIEF COMPLAINT:
_____

_____

Who referred you to this office?_____

I hereby authorize Heamin T. Shin, DPM and Shin Foot and Ankle Specialists to furnish my insurance company all information which said insurance company may request concerning my illness of injury. I hereby assign to Heamin T. Shin, DPM or Shin Foot and Ankle Specialists all payments to which I am entitled for medical and/or surgical expenses relative to the service reported for my illness or injury. I understand that I am financially responsible to said doctor for charges not covered by this assignment of benefits. A photocopy of this assignment is as valid as the original.

Patient Signature_____ Date:_____

Legal Guardian (if patient is a minor)_____ Date:_____